AUTHORIZATION FOR RELEASE OF INFORMATION

ISJ Clinic – EastRidge
Mayo Health System
101 Martin Luther King Jr. Drive, Mankato, MN 56001
Phone: 507-385-6500 Fax: 507-385-6510

Patient:	Name *(Last)*	*(First)*	*(Middle)*	Previous Name
	Address			Day Phone #
	City		State	Zip
	Date of Birth	Social Security # *(Optional)*		Medical Record #

INFORMATION TO BE DISCLOSED: ❑ Clinic ❑ Hospital ❑ Mail ❑ Pickup Appointment Date ____________

HEREBY AUTHORIZE: *(Name & Address of Releasing Facility)*
❑ Immanuel St. Joseph's Hospital ❑ Springfield Medical Center
❑ ISJ Clinic — EastRidge ❑ ISJ Clinic — NorthRidge
❑ Parkview Clinic ❑ Madelia Clinic ❑ ISJ Specialty Clinic
❑ Le Sueur Clinic ❑ St. Peter Clinic ❑ St. James Medical Center
❑ Waseca Medical Center ❑ Other ____________

TO DISCLOSE MEDICAL INFORMATION TO: *(Name & Address)* ____________

Information to be disclosed:

Information as identified below *(check all that apply)* relating to *(illness/injury)* ____________
compiled during *(visit date)* ____________

❑ Progress Sheets/Clinic Notes	❑ Emergency Room Report	❑ Cardiac Rehab
❑ Doctors Orders	❑ Operative Report	❑ Pulmonary Rehab
❑ Lab	❑ Pathology Report	❑ Occupational Health
❑ X-ray Reports	❑ Physical Therapy	❑ Psychological Report
❑ Films	❑ Occupational Therapy	❑ Chemical Dependency
❑ Discharge Summary	❑ Speech Therapy	❑ View Medical Record
❑ History & Physical	❑ Mental/Behavioral Health Notes	❑ Other ____________

All records pertaining to psychiatric/mental health, chemical dependency and/or communicable disease *(AIDS, etc. if any such information exists)* may be released unless otherwise specified here:

PURPOSE FOR DISCLOSURE:
❑ Continuation of Medical Care ❑ Payment of Claim ❑ Litigation ❑ Worker's Compensation
❑ Other *(please specify)* ____________

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome *(AIDS)*, or human immunodeficiency virus *(HIV)*. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
As stated in the Notice of Privacy, I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: ____________. If I fail to specify an expiration date, event or condition, this authorization will expire in one year. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentially rules. If I have questions about disclosure of my health information, I can contact the Health Information Department.

____________ ____________
(Signature of Patient) *(Date)*

If patient is not able to sign, please indicate relationship to patient:
❑ Parent of Minor ❑ Legal Guardian ❑ Healthcare Power of Attorney ❑ Other

ID Verification ____________ Completed By ____________ Date ____________
(Type) *(Initials)*

 White Copy To Medical Records ***Yellow Copy To Patient*** ***Pink Copy To Requesting Person/Institution***